ADULT RESIDENTIAL SERVICES

NOTICE OF ACTION

To be completed by facility.
Please print.

CLIENT NAME LAST	FIRST	MIDDLE INITIAL (MI)

SEX ☐ Male ☐ Female

FACILITY VENDOR NUMBER	CASE NUMBER

PATIENT IDENTIFICATION CODE (PIC)

FIRST INITIAL	MI	BIRTHDATE MONTH	DAY	YEAR	LAST NAME FIRST 5 LETTERS	TIE

Department of social and Health Services (DSHS)
Community Services Offices (CSO) address:

Effective date of action: _____

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TYPE OF ACTION

IF DISCHARGED OR DECEASED CHECKED, COMPLETE THE FOLLOWING INFORMATION:

AMOUNT OF REFUND	NAME ON REFUND

☐ 1. Discharged/transferred
☐ 2. Deceased
☐ 3. Social/therapeutic leave exceeds 18 days in calendar year
☐ 4. Change in payment status (includes Medicare to Medicaid, etc.)
☐ 5. Readmit to Title XIX certified facility from hospitalization
☐ 6. Admit: ☐ Pages 2 and 6 of MDS or ☐ Pages 2 and 3 of quarterly MDS attached

TRANSFER/DISCHARGE INFORMATION

If box 1 was checked above, complete the following:

☐ 1. Own home
☐ 2. Hospital
☐ 3. Nursing Facility
☐ 4. Congregate Care Facility
☐ 5. Institution
☐ 6. Institution - Institution for Mentally Retarded
☐ 7. Living with relative
☐ 8. Away without leave
☐ 9. Adult Family Home
☐ 10. Developmental Disabilities Group Home
☐ 11. Mortuary
☐ 12. COPES
☐ 13. Hospice
☐ 14. Other (specify):

NAME OF NEW FACILITY

STREET ADDRESS	CITY	STATE	ZIP CODE

REASON FOR ACTION

☐ 1. Medicare to Class 6 coinsurance
☐ 2. Class 6 coinsurance to Medicaid
☐ 3. Private pay to Medicaid
☐ 4. Medicare to Medicaid
☐ 5. Medicaid to private pay
☐ 6. Medicaid to Medicare
☐ 7. Not in need of Nursing Facility Care

COMMENTS

NURSING FACILITY REPRESENTATIVE SIGNATURE	DATE	TELEPHONE NUMBER

NAME OF NEW FACILITY

STREET ADDRESS	CITY	STATE	ZIP CODE

DSHS 15-031(X) (REV. 08/1992) (AC 02/2003) **COPIES TO:** Financial Services (CSO) Retained by Facility

NOTICE OF ACTION
ADULT RESIDENTIAL SERVICES
DSHS 15-031(X)

This form is completed by the Nursing Facility (NF), Congregate Care Facility (CCF), or Institution for the Mentally Retarded (IMR) to provide essential information to service staff of the Department of Social and Health Services (DSHS).

The purposed of the form is to enable the residential facility to promptly inform DSHS in writing of the discharge, relocation, death, social/therapeutic leave, or change in payment status of a resident on whose behalf DSHS is making payment.

Immediate notification by the facility to DSHS will:

1. Enable DSHS to provide prompt and accurate award letters.

2. Avoid departmental underpayment and overpayment to facilities.

3. Establish accurate totals of social leave.